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**Child and Family Team**  
**Performance Improvement Project Proposal**

**October 1, 2007**



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Division of Behavioral Health Services  
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## STUDY RATIONALE

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In 2007, Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) served a total of approximately 31,000 Title XIX (TIXIX) children through the Tribal/Regional Behavioral Health Authority (T/RBHA) systems. Mental health problems often influence a child’s normal development and functioning and children with serious emotional disturbance are more likely to transition into adulthood with some level of impairment. Therefore, children have been determined to be a priority population.

Research shows that strength-focused, team-based and family-centered collaborative processes of delivering mental health services for children and their families in the least restrictive setting produce better health outcomes, higher consumer satisfaction and less utilization of inpatient and residential services.<sup>1</sup> Several national studies identified family involvement as one of the promising approaches for behavioral health services to children and adolescents in managed care systems. Family involvement is essential for a child’s recovery and overall well-being, since each child possesses unique strengths, culture and needs of services. As caregivers, family members are the experts who best know their own child’s specific needs. In addition, family members have extensive knowledge and experience at the community level in planning the service delivery for their own child.<sup>2</sup> Family members and communities provide significant resources and natural supports for intensive treatment and coordination of comprehensive services.<sup>3</sup> Research indicates families are the key to sustaining and ensuring constancy and consistency in collaborative efforts regardless of administrative, staff and funding changes that affect all child-serving agencies over time. Family involvement makes the service system accountable to the family and community in ways that would not otherwise be possible.<sup>4</sup> The Child and Family Team (CFT) process is instrumental in the inclusion of the family’s unique strengths, needs, and culture in the treatment planning process to produce increased consumer satisfaction.

It is expected that the Child and Family Team process will produce a significant increase in overall collaboration with the child and family; improve collaboration with system partners involved in the child’s care; increase access to the comprehensive service array available to meet the goals and needs of the child and family; serve children and their families in the most appropriate setting; serve

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<sup>1</sup> Kendziora, K., Bruns, E., Osher, D., Pacchiano, D., & Mejia, B. (2001). Systems of Care: Promising Practices in Children’s Mental Health, 2001 Series, Volume 1. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

<sup>2</sup> Osher, T., deFur, E., Nava, C., Spencer, S., and Toth-Dennis, D. (1999). New roles for families in systems of care. Systems of Care: Promising Practices in Children’s Mental Health, 1998 Series, Volume I. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

<sup>3</sup> Stroul, B.A., (2003). Health care reform tracking project (HC RTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems –5: Serving youth with serious and complex behavioral health needs in managed care systems. Tampa, FL: Research and Training Center for Children’s Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #211-5)

<sup>4</sup> Hodges, S., Nesman, T., and Hernandez, M. (1999). Promising practices: Building collaboration in systems of care. Systems of Care: Promising Practices in Children’s Mental Health, 1998 Series, Volume VI. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

children and families in a manner that promotes their unique cultural heritage, strengths and needs and provide timely, convenient services to promote independence and the use of natural supports to enhance the quality of the lives of Arizona's youth and families. For the purposes of this PIP, increased CFT involvement and improved child and family reported outcomes will be the desired measurements. ADHS/DBHS has additional monitoring and measurement activities to capture other proxy measures as a result of CFT implementation, such as the annual Consumer Satisfaction Survey and CIS data.

ADHS is committed to serving all enrolled Title XIX (TXIX) behavioral health recipients under the age of 21 through the CFT Practice Protocol. However, for the purpose of this PIP, enrolled TXIX children aged 5-17 will comprise the study population. Review of the DBHS 2006 Consumer Satisfaction Survey indicates that: the 5-17 year age band comprises the largest number of child enrollees and that 64% of those surveyed were involved with a CFT. However, responses pertaining to outcomes yielded an overall positive response rate of 62%. The 2005 Consumer Survey data indicates that only 60% of surveyed children and families reported positive outcomes. ADHS/DBHS poses the hypothesis that an increase in the number of TXIX children served through the CFT process will lead to an increase in reported outcomes. The outcomes captured through the Consumer Satisfaction Survey are as follows:

- My child is better at handling daily life.
- My child gets along better with family members.
- My child gets along better with friends and other people.
- My child is doing better in school and/or work.
- My child is better able to cope when things go wrong.
- I am satisfied with our family life right now.

ADHS has worked to create the infrastructure to adhere to its goals, including enhancing the service array, increasing network capacity, and educating system partners on the CFT process. As of June 2007, data from ADHS' Client Information System (CIS) identified that 47% of T/RBHA-TXIX behavioral health recipients under the age of 21 were served by a CFT. As the ultimate goal is for all children to be served by CFTs, ADHS/DBHS identified the need for a Performance Improvement Project designed to implement specific interventions to reach this goal and increase the reported positive outcomes for enrolled children and their families.

ADHS has defined the composition of a CFT as a group of people that includes, at a minimum, the child and his/her family, any foster parents, a behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. This may include, for example, teachers, extended family members, friends and other natural supports; family support partners, healthcare providers, coaches, community resource providers; representatives from churches, synagogues or mosques; and multiple system partners such as Child Protective Services and the Division of Developmental Disabilities. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, and by which individuals are needed to develop and coordinate an effective service plan, and can therefore expand

and contract as necessary to be successful on behalf of the child. Furthermore, a functioning CFT must meet the following criteria:

1. Have a Strengths, Needs and Cultural Discovery completed;
2. Must have met at least once and since then, has continued to function with ADHS Technical Assistance Document #3, The Child and Family Team Process;
3. Must be lead by a trained facilitator or Child and Family Team Coordinator/ Case Manager.<sup>5</sup>

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## **STUDY QUESTION**

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The following question will guide the CFT PIP study:

- Will an increase in the number of TXIX children served through the CFT process lead to an increase in reported outcomes?

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## **IMPLEMENTATION TIME FRAME**

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The proposed implementation date is January 1, 2008, by which time members of the Project Workgroup will be identified. The first Workgroup meeting will be held by March 1, 2008 and then at least quarterly throughout the course of the PIP.

Year 1 of the Project will focus on forming the Project Workgroup, identifying possible interventions, and potential barriers to implementation. Year 1 progress will be measured on June 30, 2008.

Year 2 will focus on implementation of proposed interventions, measurement of progress toward the goal, and development of improvement activities, as needed. For Year 2 of the Project, measurement will be taken on June 30, 2009.

In Year 3, the Workgroup will continue with successful interventions, measure progress, and plan for sustainability. The measurement for Year 3 will occur on June 30, 2010.

In Year 4, the Workgroup will monitor to ensure sustainability of demonstrable improvement and take action, as appropriate. The final measurement will occur on June 30, 2011.

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## **INTERVENTIONS**

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The proposed interventions are:

- Conduct a CFT PIP Workgroup to incorporate input from stakeholders including families, developers, administrators, and policy makers. RBHA staff, Clinical Liaisons, case managers, service providers, administrators, families, and community members will be included in the focus group study. Participants will be chosen to reflect multiple settings and needs, including rural and urban communities. After identifying the promising intervention strategies

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<sup>5</sup> Technical Assistance Document 3: Child and Family Process <http://www.azdhs.gov/bhs/guidance/cfttd.pdf>

to improve CFT practice performance, the findings will be disseminated to the stakeholders and the public to increase the awareness and support in the community. In addition, ADHS will guide RBHAs on the CFT expansion plans and assist RBHAs with CFT performance improvement interventions to increase the number of CFTs;

- Involve family members at both the individual and system level to increase family participation and empower the family to express voice and choice through CFT practice through participation in the annual Consumer Survey, Family Advisory Committee and Wrap Around Fidelity Assessment System (WFAS) implementation;
- Identify and train potential CFT Case Managers/facilitators to increase capacity;
- Monitor, implement and evaluate CFT performance improvement measurements such as CIS data, the Consumer Satisfaction Survey, T/RBHA CFT Expansion Plans and outcomes of the WFAS;
- Consistent and quarterly review of performance data by ADHS with the RBHA Directors and Quality Management Coordinators to create an immediate feedback loop to address CFT expansion utilizing capacity, enrollment and outcome data.
- Consistent evaluation of data to identify system and T/RBHA specific barriers to identify solutions for improved performance.

To sustain the performance improvements that are expected from the full implementation of CFT involvement for all children and to ensure the integrity and quality of the CFT practice requires strategies at multiple levels: policy, provider, and practice. Policies and legislation at the federal and state level have been established to support the CFT practice, thus facilitating development of integrated service systems and planning, as well as funding streams and incentives. ADHS has developed standards for the CFT practice and will establish the quality assurance mechanisms. At the provider level, change will happen as the result of developing community collaborative structures and cross-agency policies to support the development of the CFT practice and increase the number of children receiving services using this practice approach.

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## METHODOLOGY

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### Measurement Period

The study measurement period is annually with the first measurement being completed on June 30, 2008. The target time frame to reach the benchmarks of 95% of enrolled TXIX children aged 5-17 served by a CFT and 85% reporting positive outcomes is by June 30, 2010. The study will continue to be monitored one additional year to demonstrate sustainability. All CFT-PIP information will be analyzed and presented to AHCCCS in quarterly interim reports, as contractually agreed upon in the DBHS/AHCCCS Contract 07-08.

### Population

All TXIX behavioral health recipients aged 5 to 17 receiving services through the T/RBHA system at

the time of the measurement are eligible for this study.

### **Sampling Methodology**

To determine the percentage of TXIX children served through the CFT process, all TXIX behavioral health recipients aged 5 to 17 with a complete demographic data set in ADHS' Client Information System (CIS) at the time of the measurement will be included in the sample. Per ADHS policy, all behavioral health recipients must have a completed demographic in CIS within 55 days of intake.

Child and family reported outcomes will be measured through the Annual Consumer Survey. For the annual Consumer Survey, the sample frame is composed of all behavioral health recipients aged 5-17 enrolled as of January, 2007, who meet the following criteria:

1. The behavioral health recipient must have received a community based, mental health service other than transportation, laboratory and/or radiology services, or crisis services within the most recent six months;
2. The behavioral health recipient must not be receiving services in an inpatient setting at the time the sample frame is developed.

The following behavioral health recipients will be excluded from the sample frame:

1. Recipients who have been disenrolled from the system, as the project focuses on currently enrolled persons.
2. Children receiving services from fee-for-service providers, as this provider type was excluded from the survey to relieve administrative burden, particularly as it applies to providers in Pima and Southern Arizona counties.
3. Children receiving services from ValueOptions', the previous vendor in Maricopa County, "small" providers, serving less than 75 behavioral health recipients, as this is representative of approximately 1% of the total Maricopa County Provider.

ADHS/DBHS determines the survey sample size stratified at the RBHA level utilizing a statistically valid process with a 90% confidence level and a confidence interval of 5%. The sample size is adjusted by 50% to allow for over sampling cases. ADHS/DBHS provides the RBHAs with the calculated sample frame, including the over sample. Each RBHA then conducts a stratified random selection of behavioral health recipients using an SPSS random sampling program. The RBHAs review their sample lists to determine that at least 85% of the selected consumers have scheduled appointments during the survey period, repeating the random selection process until this criterion is satisfied.

### **Data Collection Methods**

Data will be extracted from the Client Information System (CIS) and analyzed on a biannual basis to monitor the increase in the number of CFTs. Annually, on June 30<sup>th</sup>, a snapshot of the CIS data system will be conducted to compare the performance indicators with previous years.

CIS data is collected through the initial intake assessment, which is completed by clinical staff who meet a set of minimum qualifications and are privileged to complete this process, and is updated at least annually, or when a significant change in the behavioral health recipient's circumstances is identified. The privileging process includes the successful completion of training on the assessment

process. In addition, Behavioral Health Technicians who wish to be privileged to complete assessments must demonstrate the successful completion of a minimum of 3 assessments, as determined by a behavioral health professional. It is during the privileging process that inter-rater reliability is established. Individuals who do not successfully complete the privileging process are provided with additional training and clinical supervision and may re-apply for privileging status at a later date.

Data that is entered into the ADHS CIS is validated through a series of system edits that check for valid values and logic. Data files that contain incomplete or inaccurate data are sent back to the RBHA and are subject to sanction. To further improve the reliability of data entered into the CIS, ADHS has used the CIS File Layouts and Specifications Manual to provide guidance for each file passing between the Client Information System (CIS), each Regional Behavioral Health Authority (RBHA), and each Tribal Regional Behavioral Health Authority (TRBHA).

The following actions have been taken to ensure proper documentation/data collection process:

- The CIS data book is used to assist each T/RBHA with ensuring accuracy of data and in the development and/or maintenance of programming and other processes.
- Implementation of standardized data collection and information tracking procedures,
- Implementation of sanctions for all incomplete demographics that do not meet established timeframes for submission (55 days post-intake), beginning January 1, 2007.

Data will also be extracted from the Annual Consumer Survey and analyzed on an annual basis to monitor families' reported outcomes. At Survey's end, an evaluation of the Survey data will be conducted to compare the performance indicators with previous years. The following actions have been taken to ensure proper Survey administration:

- Training of RBHA staff on Survey Protocol and administration process;
- Development of a Survey administration flow chart, timelines and deliverables for easy reference and guidance;
- Development of SPSS syntax to process and analyze data;
- Provision of data files containing Survey responses to each RBHA;
- ADHS/DBHS technical assistance in data interpretation and analytical methods.

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## **CONFIDENTIALITY PLAN**

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All transactions through the CIS have been determined to be HIPAA compliant and T/RBHAs have been required to attest to that fact. In addition, the protection of confidential information is covered in the ADHS Policy 2.54 "Confidentiality". Research and evaluation activities are addressed in sections F. 7.g. (4) (b), F. 7.g. (4) (c) and F.9.b. (3)

Data will be presented at the aggregate level and will not include any personal health information that

may identify a particular client in the report.

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## PERFORMANCE INDICATORS

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The following performance indicators will be used for the duration of this project::

1. Percentage of TXIX Behavioral Health Recipients aged 5-17 Receiving Services through the CFT Process

Numerator: Total number of complete demographic records for TXIX behavioral health recipients aged 5-17 that contain a “Y” (Yes) in the CFT field.

Denominator: Total number of TXIX behavioral health recipients aged 5-17 with a complete demographic record.

2. Outcomes

Numerator: Total number of behavioral health recipients aged 5-17 reporting positively on outcomes.

Denominator: Total number of TXIX behavioral health recipients aged 5-17 who had Surveys completed.

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## ANALYSIS PLAN / EVALUATION/BENCHMARK

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Baseline data shows that as June 2007, 47% of T/RBHA-TXIX behavioral health recipients aged 5 to 17 were served by a functioning CFT. This performance measure indicator will be analyzed and evaluated through interim monitoring with measurement reported on an annual basis to AHCCCS through the CFT PIP Interim Report. Data will be analyzed and reported as follows:

- Data will be stratified by T/RBHA and Geographic Service Area (GSA).
- Statewide data will be analyzed and reported for the proposed indicators.
- Barriers to CFT implementation will be evaluated and reported.
- Interventions will be evaluated and modified, as necessary, based on data results. This evaluation will be included in annual reports.

Presentation of results will include tables and graphs in the interim and final reports. A narrative analysis of results will accompany the graphical and tabular presentation of data.

Performance indicators will be measured January 1 and June 30 of each fiscal year to assess progress toward the stated goal, although interim monitoring will occur on a quarterly basis. This information will be reviewed by the project workgroup and T/RBHAs that do not show incremental progress toward the goal or fail to meet established benchmarks will be required to implement performance

improvement plans that include planned interventions and interim monitoring.

Benchmarks have been developed in accordance with ADHS/DBHS CFT practice standards and Consumer Survey responses for monitoring purposes. ADHS/DBHS's ultimate goal is to implement CFTs for all TXIX enrolled children, increasing the number of families reporting positively on outcomes. Therefore, for the percentage of CFTs among TXIX enrolled children aged 5-17, the benchmark will be compared with the AHCCCS/ADHS/DBHS established standards for compliance during the three years of CFT PIP implementation, as follows:

- Year 1 (June 30, 2008): 45%
- Year 2 (June 30, 2009): 70%
- Year 3 (June 30, 2010): 95%

For the number of behavioral health recipients aged 5-17 reporting satisfaction with outcomes, the benchmark will be compared with the ADHS/DBHS established performance standards for the Annual Consumer Survey Outcomes Domain, as follows:

- Year 1 (June 30, 2008): 72%
- Year 2 (June 30, 2009): 80%
- Year 3 (June 30, 2010): 85%

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## **DATA LIMITATIONS**

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The effectiveness of interventions to improve data collection may confound the 'true' impact of the interventions on improvement of CFT implementation resulting in increased positive consumer and family reporting of outcomes. It is important to observe caution in interpreting the data and isolating the effect of any improvement in the process of measurement and monitoring as opposed to the 'true' effect of a direct intervention in improving CFT implementation and increase in reported positive outcomes. However, there are no known data limitations for this project.